Wyoming Department of Health
Commit to your health.

Behavioral Health Division

Case Management Selection

Please check the appropriate waiver:

- ☐ Adult Developmental Disabilities (DD) Waiver
- ☐ Child Developmental Disabilities (DD) Waiver
- ☐ Acquired Brain Injury (ABI) Waiver
- ☐ Comprehensive Waiver
- ☐ Supports Waiver

Applicant: _____
(First) (Last)

Legal Guardian: _____
(First) (Last)

Acknowledgement of Choice of Providers and Case Manager Conflict of Interest Disclosure

Please initial each line verifying services available through this waiver program have been explained to you.

_____ I understand that I have the ability to make decisions regarding what services will be provided and which providers we will work with while he/she is a waiver participant.

_____ I understand that I have a right to request informal dispute resolution or an Administrative Hearing if not given the choice of providers.

_____ I understand that I can choose a case manager not affiliated with any of my other services; however, if the case manager is providing other services on my plan or works for an organization providing me other services, this may be a conflict of interest and it must be disclosed.

Case Manager Selection

A list of DD Section certified case managers available in my region was shared with me and my questions have been answered. I have chosen the following individual to act as my case manager to assist in gathering the necessary information to prepare my clinical eligibility and, if eligible for services, to assemble and submit the Individualized Plan of Care.

I understand that I may choose a different case manager at a later date.

Case Manager Name:_____ Organization: _____

Federal Provider ID (NPI):_____ Wyoming Provider ID: _____

If this selection is to make a change, my existing Case Manager is: _____

Federal Provider ID (NPI):_____ Wyoming Provider ID: _____

Effective Date of Change to New Case Manager:_____

Consent for Information Release

Please initial each line verifying your understanding of this information.

_____ I agree to participate in assessments/screenings to determine clinical eligibility and the need for HCBS waiver services.

_____ I authorize the release of information by my physician, hospital, community mental health center, other social service providers, school, health service providers and family members to and among state agencies and their agents on my child's medical condition and other relevant information necessary to determine appropriate HCBS waiver services. I understand I may revoke this release of information in writing at any time.

Signatures

_____ __/__/_____
Signature of Applicant or Legally Responsible Representative Date

_____ __/__/_____
Signature of Selected/Current Case Manager Date

_____ __/__/_____
Signature of Witness Date
(required if the signature is marked with an "X")

_____ __/__/_____
Signature of New Case Manager Date

Mail this form to DD Section Participant Support Specialist: BHD Developmental Disabilities Section
6101 Yellowstone Road; Suite 220 Cheyenne, WY 82002